Department of Health

Tamara Finkelstein
Chief Operating Officer

Richmond House
79 Whitehall
London
SW1A 2NS

[redacted]

Mr N Meadows
Senior Coroner
The Coroners Court,
Manchester Town Hall,
Albert Square,
Manchester,
M60 2LA

29 April 2015

Dear Mr Meadows

Thank you for your letter following the inquest into the death of Kimberley Lindfield. I was very sorry to hear of Ms Lindfield's death and wish to extend my sincere condolences to her family.

The inquest concluded that Ms Lindfield died as a result of misadventure contributed to by neglect and you point out a number of failures in her care. In particular, there was failure:

- to refer her for mental health assessment upon admission;
- to make appropriate clinical records of her increased level of observations as a result of her self-harming behaviour;
- to make appropriate clinical records of her interactions with nursing and clinical support staff and any indications of intent of suicide/self- harm;
- to assess and take clinical action to ensure her health and safety;
- to note that she was recommended to have continuing cardiac monitoring; and
- to ensure that clinical staff were aware of and implemented the policy of referral for mental health assessment asap where patients were suffering from mental disorder or self-harming.

As a result of these failures, you have a number of concerns. To summarise:

a) University Hospitals of South Manchester (UHSM) and Manchester Mental Health and Social Care NHS Trust (MHSC) had agreed a joint understanding and approach to the assessment of all mental health patients following the death of Paul Deans in 2009. Assessment should take place as soon as possible upon referral. However, there was no audit of whether this was happening in practice so there was no assurance the system was working.

b) There should be clear written policy or protocol setting out what an increased level of observations for mental health patients actually involves. For example, it should be clear what "once in every 15 minutes" means in practice and what should be recorded. There should be a clear chain of responsibility to ensure this is carried out.

c) Written protocol or guidance is needed for appropriate clinical review. Changes should be made and recorded for care and management plans in response to new or changed circumstances or new risks.

d) All UHSM nursing and clinical staff should be reminded about good record keeping. There should be periodic audits of record keeping that ensures appropriate standards are met.

e) Other NHS Trusts, who may have similar policies/protocols concerning referral for mental health assessment, should be informed about this case and have opportunity to learn and amend their systems.

In this case, many of your concerns and criticisms appear to be levelled at UHSM. I note that you have sent a copy of your report to UHSM and I trust that they will respond to your concerns in full.

I also note that the actions of some clinical staff involved in the hospital care are subject to criticism – you point out breaches in the nurse record keeping, for example. Concerns about the fitness to practise of a doctor or nurse should be raised with the appropriate independent professional regulatory body. The General Medical Council (GMC) is the independent regulator of medical doctors and the Nursing and Midwifery Council (NMC) is the independent regulator of nurses and midwives.

Where an allegation is made about a registrant the GMC/NMC have a duty to investigate and, where necessary, take action to safeguard the health and well-being of the public. The Department does not get involved with, or comment on, individual cases.

NHS England has already responded to your Regulation 28 report. I note that NHS England is keen to learn from the findings of your inquest, particularly in relation to suicide prevention for people admitted for acute medical or surgical care after an earlier suicide attempt.

NHS England has discussed possible action to prevent future deaths with clinical and patient safety experts, including its Mental Health Patient Safety Expert group. NHS England plans to update its Suicide Prevention Audit Tool for Emergency Care, in light of learning from suicides in acute care settings. This stresses the importance of engagement with the patient, the recording of observations and the timeliness of mental health assessment.

Further guidelines for patient observation are contained in the Mental Health Act 1983 Code of Practice. This has recently been reviewed by the Department of Health and the revised edition came into effect on 1st April 2015. Within this code is a section which advises on enhanced observation for patients in hospital wards and services.

For mental health assessments, NICE guidelines on self-harm (CG16 and CG133) state that Emergency Departments should refer all those who present with self-harm for a psychosocial assessment. They can be found at:

http://www.nice.org.uk/guidance/cg16/chapter/1-recommendations#the-treatment-and-management-of-self-harm-in-emergency-departments

*Preventing suicide in England: A cross-government outcomes strategy to save lives, (*published in September 2012), also recognises the importance of such assessments.

In the Department's current *Public Health Outcomes Framework* a new self-harm indicator was introduced; this measures:

- Attendances at Emergency Departments for self-harm per 100,000 population

- Percentage of attendances at Emergency Departments for self-harm that received a psychosocial assessment.
- This two-part indicator is intended to demonstrate the prevalence of self-harm and also the quality of response from Emergency Departments.

The Mental Health Action Plan, *Closing the Gap: Priorities for Essential Change in Mental Health* (published by the Department in January 2014), set out a number of changes for the NHS and social care to make in the next few years to improve the lives of people with mental health problems and help reduce health inequalities.

The Multicentre Study of Self-harm in England (funded by DH) is collecting data on national and regional trends in self-harm presenting to health services, including data on methods of self-harm, how self-harm is managed, compliance with national guidance, and self-harm in young people and in different ethnic groups.

The current suicide prevention strategy is backed by up to £1.5 million funding for suicide prevention research. This funding is being invested over three years into six projects, four of which are researching different elements of self-harm:

- Understanding and helping looked-after young people who self-harm
- Understanding lesbian, gay, bisexual and trans adolescents' suicide, self-harm and help-seeking behaviour
- Self-harm in primary care patients: a nationally representative cohort study examining patterns of attendance, treatment and referral, and risk of self-harm repetition, suicide and other causes of premature death
- Risk and resilience: self-harm and suicide ideation, attempts and completion among high risk groups and the population as a whole.

I hope that this response is helpful and I am grateful to you for bringing the tragic circumstances of Ms Lindfield’s death to my attention.

Yours sincerely

TAMARA FINKELSTEIN